TESTIMONY OF

HONORABLE M.D. GOETZ, JR.

REGARDING H.R. 1229

BEFORE THE

HOUSE OF REPRESENTATIVES JUDICIARY COMMITTEE

SUBCOMMITTEE ON COURTS, THE INTERNET, & INTELLECTUAL PROPERTY

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Thank you, Mr. Chairman, and members of the House Judiciary Committee, for allowing me to testify today. My name is Dave Goetz, and I am the Commissioner of Finance and Administration for the State of Tennessee. In my role as Commissioner, I act as the Tennessee official charged with overseeing and formulating policy for our State's Medicaid program, TennCare. I am here today to testify about Tennessee's experience with negotiated consent decrees, specifically in the context of our State's Medicaid program, and how my ability to perform my duties has been severely handicapped by the existence of several consent decrees negotiated and signed by previous state administrations. As I will detail, the State's best efforts to contain the costs of and thereby save our health care program in the face of dire fiscal stress have been continuously and consistently burdened by oppressive consent decrees, consent decrees that place policy-making power in the hands of the federal judiciary.

First, I'd like to explain the reality of the world that we face in Tennessee. Our Medicaid program, TennCare, was the first state Medicaid program to move entirely to managed care, and it has continued as one of the most generous programs in the country, providing health care to one-fifth of the State's population. Indeed, we provide greater coverage than any other state, covering those who would otherwise not be covered, including those who are uninsurable and women who, though no longer eligible for federal welfare assistance, are still below the poverty level. But the generosity of the program has come with overwhelming costs. Indeed, TennCare consumed 33.9 and 33.3 percent of the State's total spending over the last two years, the highest of any State in the country and well in excess of the national averages. And without change to the program, by fiscal year 2007, as much as $1 billion in new revenue would be needed to fund the TennCare program. In the fall of 2004, skyrocketing utilization levels and costs of TennCare became a crisis. Projections revealed that, absent reform, TennCare's expenses during

the fiscal year 2006 (which begins July 1, 2005) would increase by some $650 million in State funds, well in excess of Tennessee's growth in revenue. Indeed, without reform, the State would have been forced to impose drastic cuts on the remainder of the State's budget, including education, transportation, and public safety programs. Thus, during the fall of 2004, the State conducted a detailed and thorough consideration of all available reform alternatives. It was (and remains) the State's strong preference to obtain the necessary cost savings through means other than disenrollment. In September of 2004, the State submitted its first reform package, described by the Governor as the "the silver rather than platinum coverage." This reform initiative secured the necessary cost savings through innovations on drug coverage and benefits limits rather than disenrollments.

Unfortunately, however, because of the severe restrictions imposed by one consent decree, in the *Grier* litigation, disenrollments became necessary. The *Grier* suit was first filed in 1979, and a succession of consent decrees (the most recent of which was entered in 1999) have governed the State's Medicaid program ever since. The *Grier* consent decree, which extends significantly beyond the requirements imposed by federal law, precludes implementation of such standard cost-savings measures as an effective prior authorization pharmacy regime and effective managed care. And the financial impact of the decree has been devastating. For example, to focus on pharmacy: in fiscal year 2001 alone, TennCare's pharmacy costs increased by an astounding 44.7 percent. And since 2000, TennCare's pharmacy costs have *more than tripled*, rising from $716.3 million in FY2000 to a projected $2.557 billion in FY2005. Though rising pharmacy costs may be a problem for all state Medicaid programs – indeed, for all health care programs – no State has experienced anything approaching the magnitude of growth that TennCare has endured. In contrast to Tennessee's exploding pharmacy costs, the average

annual percentage increase in Medicaid pharmacy spending per enrollee nationwide between 2000 and 2003 was only 12.6 percent. Tennessee now spends more per person on drugs than any other state. While the national average for prescriptions per person per year is 10.5, Tennessee's average is 17.9.

This administration came into office promising to reform TennCare. We had hoped that we could work with counsel for the plaintiffs to secure the needed reform. In fact, in March of 2003, we initiated and participated in a lengthy series of meetings with plaintiffs' counsel, hoping that by working together, we could save this program. Our main goal was to implement a pharmaceutical initiative that already exists in most other states, a Preferred Drug List with a genuine prior authorization requirement for nonpreferred drugs. Negotiations were difficult, and only produced limited changes to the decree. Our ability to implement a functional and effective Preferred Drug List was still precluded by other provisions of the *Grier* consent decree, and Plaintiffs would not agree to the needed modifications. Without the policy-making freedom to contain costs through these standard prior authorization measures, the State found that its options for containing costs and for sustaining the program were extremely limited. And thus Governor Bredesen was finally forced, on January 10 of this year, to propose a comprehensive reform package that entailed both disenrollments of beneficiaries in optional Medicaid categories and benefit reductions for remaining beneficiaries in mandatory coverage categories.

Now, in an attempt to ameliorate the extent of the disenrollments, the State has proposed a new spend down program, which is designed to serve up to 100,000 of the neediest Tennesseans who will otherwise be disenrolled. But, once again, implementation of this new program depends upon the State's ability to generate the necessary cost-savings through other means, and that, in turn, depends upon the State's ability to implement reforms that are currently

blocked by the restrictive terms of the *Grier* consent decree. Once again, the plaintiffs in this case refuse to agree to such modification. And, therefore, the State now finds itself once again before a federal judge, where the State must seek a court order to modify a decree that was originally signed in 1986. In the process, the State must expend significant resources that could otherwise be spent on enrollees, and do so in the hopes of being free to implement health care programs and procedures that are standard for other states throughout the country.

This present litigation, however, is not the first time the Governor's present reform package has been the subject of consent decree based litigation. In January of this year, a federal district court judge in Nashville used another consent decree to issue an order that completely blocked the Governor's reform package from going forward. This particular consent decree, originally signed in 2001 in the *Rosen* litigation, was initially negotiated to secure certain procedural protections to enrollees before their benefits may be terminated. Nowhere in that consent decree are the State's substantive policy choices discussed or limited. Nonetheless, the federal district judge read such limitations into the *Rosen* consent decree. And although all parties agreed that the authority of the State to change its eligibility standards was not properly before the court, the district court, on its own, ordered the State of Tennessee to come before the court and offer justification and evidentiary support for the State's policy decision to disenroll some classes of TennCare beneficiaries.

To be clear, this reform package, including the disenrollments, had been specifically authorized by the Tennessee legislature and carefully designed by State officials after extensive review of all available options. Moreover, the reform package was blessed by the Centers for Medicare and Medicaid Services (also known as CMS), the federal agency responsible for enacting and implementing the federal Medicaid regulations. Notwithstanding CMS's approvals,

the district court judge held extensive hearings reviewing the State's policy rationales and choices. In the course of these proceedings, the State was forced to endure extensive discovery and expend vast resources defending its policy decision. The Court of Appeals for the Sixth Circuit ultimately reversed this judicial inquiry into the State's policy-making prerogatives involving Tennessee's Medicaid program. But even after the Sixth Circuit had upheld the State's authority to implement the substantive policy choices contained in the reform package, the district court enjoined implementation of the reforms, holding that the State had not provided for adequate notice and opportunity for hearing to disenrollees. Despite the fact that CMS had specifically approved the very procedures at issue, the district court issued an injunctive order forbidding the State from going forward with the disenrollments because, he asserted, the procedures did not live up to the requirements contained in the consent decree. The court's decision only infused greater delay and uncertainty into the reform process. Fortunately, the Sixth Circuit once again reversed the district court's injunctive order. Though the State was eventually able to move forward with reform, it could do so only after significant time and resources had been devoted to this unnecessary, protracted litigation.

As these examples demonstrate, the present practice of permitting elected government officials to immunize their policy decisions from political change by entering into perpetual consent decrees has proven unworkable. Rather than protecting constitutional rights, these consent decrees have hamstrung our State officials, making it difficult for them to manage effective operations and even more difficult for them to respond to new conditions by designing and implementing reform measures that are necessary for the good of the entire State. Indeed, particularly in the health care realm, officials need flexibility to respond to complex social and financial dynamics, allowing them to make important policy choices regarding the proper

allocation of available resources to best serve those in the health care program while continuing to serve the interests of the whole community. Rather than protecting the TennCare beneficiaries, these consent decrees have become the principle roadblocks to preserving effective managed care for the greatest number of Tennesseans.

As the Tennessee experience illustrates, when consent decrees are allowed to exist perpetually, state officials with responsibility for administering the program at issue are unduly constrained by plaintiffs' attorneys and federal judges. Indeed, under our federalist system of government, consent decrees governing state institutions should not last forever. By their very nature, they involve federal judicial supervision over a function that our system of government has assigned to the political branches of state government. Such supervision may be appropriate and is justified by the original consent of the state and by the felt need to address an alleged violation of federal law (even where, as here, the State has denied the allegation and it has never been adjudicated). However, neither of those justifications supports the perpetual governance by consent decree of a state institution.

It is common sense that a federal court's regulatory control of a state institution should not extend beyond the time required to remedy the effects of past violations. And the requirement that federal courts return control of state institutions to the state flows logically from the fact that the only justification for displacement of the authority entrusted to the local officials is the presence of a federal constitutional or statutory violation and a consent decree designed to alleviate such a violation is only justifiable as long as it continues to do so. Thus, when the alleged violation of federal law that gave rise to the decree in the first place has been remedied, continued imposition of a consent decree is no longer justified. And when the purposes of the consent decree have been achieved, responsibility for discharging the State's obligations should

be promptly returned to the State and its officials. As our recent experiences in Tennessee illustrate, however, such responsibility is not returned to the state officials without an expensive and protracted fight. Rather, these consent decrees continue to exist; they pervade every aspect of the state's decision-making; hinder every attempt at innovation; constrain necessary reform; and grant federal judges undue authority to review every aspect of the state's programs. Legislation like that before this Committee is desperately needed to return control over state institutions to the states.

It is also improper to allow an agreement by one elected administration or one official to forever thwart the democratic process, for inherent in our democratic system of government (both state and federal) is the right of each generation of elected and appointed officials to alter the course chartered by their predecessors. To allow a consent decree to go on perpetually is to bind all future officers of the State, regardless of their view about whether the relief contained therein was necessary or desirable. And this is how they are currently practiced: consent decrees in institutional reform cases are often written to last for all time, and when a district court signs off on these agreements, it reflects a belief that the commitments embodied in these agreements should run perpetually. Thus, by allowing this form of perpetual consent decree, we grant to one state official the power to bind the government and its future officials. New officials, who were not parties to the agreement, are unable to move forward with the policies they were elected by the People to implement, and are thus unable to put into practice their new insights and solutions to the problems of allocating revenues and resources. This ought to change. The foundational principles of representative democracy do not permit elected public officials to bind the body politic long after they have left office. The policy-making decisions of previous administrations,

and previous generations, should not be binding on future generations and their elected representatives.

Finally, consent decrees not only tie the hands of future administrations, but they also undermine the democratic process by allowing governments to do by litigation that which they could not do with elected majorities. Indeed, when we tolerate perpetual consent decrees, we are tolerating a system that encourages elected officials to implement their policy choices through negotiated consent decrees rather than to achieve such policies by their own authority, as given to them by popular or legislative enactments.

In closing, I would simply like to reiterate that the legislation presently pending before this Committee is of vital importance. Across this country, consent decrees continue to tie the hands of state officials in ways that do not comport with basic democratic principles. But this issue is not merely theoretical. Tennessee's efforts to address the intractable problems of runaway medical and pharmacy costs of its Medicaid program should serve as an example of cooperative, bipartisan federalism. Our State's administration under Governor Bredesen's leadership has worked closely and cooperatively with CMS, under the leadership of President Bush's Commissioner, Dr. McClellan, to identify practical solutions to difficult problems. The solutions agreed to by our State and federal elected and appointed officials should not be subject to the approval of plaintiffs' counsel or a federal judge. By binding future state officials, bestowing upon federal judges inappropriate review over policy-making authority, and ultimately undermining the policy-making functions of the elected branches of government, consent decrees often function in ways that can have devastating consequences for the health and well-being of the people.